

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10245

10255

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u>		c. LENGTH OF STAY IN 1b <u>56 yr</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent's Queen Anne's Co Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>C</u> Last <u>Ashley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/03</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Ashley</u>		14. MOTHER'S MAIDEN NAME <u>CLARA ASHLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-16-7052</u>	
17. INFORMANT Address <u>Mrs. Mae Ashley = Rock Hall Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure &amp; pulmonary edema</u> DUE TO (c) <u>82 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/23/58</u> , 19 <u>58</u> , to <u>9/4/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/4/58</u> , 19 <u>58</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall Ind</u> DATE SIGNED <u>9/4</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GATEWOOD</u>		<u>Rock Hall Ind</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Sam</u> ADDRESS <u>Church Hill Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>WILLIAM W. WILSON</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>May 10, 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
13. PLACE OF BIRTH <i>Baltimore, Md.</i>		14. DATE OF BIRTH <i>May 10, 1868</i>		15. OCCUPATION <i>Teacher</i>	
16. MARITAL STATUS <i>Married</i>		17. NAME OF SPOUSE <i>Anna Wilson</i>		18. NAME OF CHILDREN <i>John, Mary, William</i>	
19. PREVIOUS DEATHS <i>None</i>		20. PREVIOUS INJURIES <i>None</i>		21. PREVIOUS DISEASES <i>None</i>	
22. SIGNATURE OF DECEASED <i>None</i>		23. SIGNATURE OF NEXT OF KIN <i>None</i>		24. SIGNATURE OF OTHER WITNESSES <i>None</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10263 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rock Hall</u>	
c. LENGTH OF STAY IN TB <u>27 Days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Duane Baker</u>		4. DATE OF DEATH Month Day Year <u>Sept 12 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 1958</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald Harold Baker</u>		14. MOTHER'S MAIDEN NAME <u>Brenda Beck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>HAROLD BAKER</u>		Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 11</u> , 1958, to <u>Sept 12</u> , 1958, that I last saw the deceased alive on <u>Sept 11</u> , 1958, and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. M. Batwood</u>		DATE SIGNED <u>Sept 13/58</u>	
PHYSICIAN'S NAME (Type)		ADDRESS <u>Rock Hall</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>13/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

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CERTIFICATE OF DEATH

NAME OF DECEASED HARRY J. BAKER		SEX Male		AGE 45	
DATE OF DEATH 1944		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		DISEASE OR INJURY None		MANNER OF DEATH Natural	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 1900		OCCUPATION Clerk	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL None		NAME OF NURSE None	
NAME OF FUNERAL HOME J. H. Smith & Co.		NAME OF CEMETERY Greenwood		NAME OF MINISTER Rev. J. H. Smith	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF SURVIVOR None		NAME OF WITNESS Dr. J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith		NAME OF ASSISTANT J. H. Smith	
NAME OF DECEASED HARRY J. BAKER		SEX Male		AGE 45	
DATE OF DEATH 1944		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		DISEASE OR INJURY None		MANNER OF DEATH Natural	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 1900		OCCUPATION Clerk	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL None		NAME OF NURSE None	
NAME OF FUNERAL HOME J. H. Smith & Co.		NAME OF CEMETERY Greenwood		NAME OF MINISTER Rev. J. H. Smith	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF SURVIVOR None		NAME OF WITNESS Dr. J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith		NAME OF ASSISTANT J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>NATHANAEL S. BRAMBLE</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July, 24, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b>	11. IF UNDER 24 HRS. Hours <b>4</b> Min. <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Bus Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Bus</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bramble</b>		14. MOTHER'S MAIDEN NAME <b>Addie Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>221-10-0531</b>	
17. INFORMANT <b>Mrs. Mary A. Bramble</b>		Address <b>Millington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 24, 1958</b> , to <b>Sept 7, 1958</b> , that I last saw the deceased alive on <b>Sept 7, 1958</b> , and that death occurred at <b>1:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. H. Hamilton</b>		ADDRESS (Street, city or town, state) <b>Millington, Md.</b> DATE SIGNED <b>9/8/58</b>	
PHYSICIAN'S NAME (Type) <b>H. H. HAMILTON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 10, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Millington, Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Millington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b> ADDRESS <b>Millington, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 10 '58</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5, 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 25, 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		JAN 25, 1968		MOBILE		MOBILE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION		STATE OF REGISTRATION		COUNTRY OF REGISTRATION		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION	
JAN 25, 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		JAN 25, 1968		MOBILE		MOBILE	

10 HOURS OF TALKS BY GARY K. ...  
TO ...  
...

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10248

Reg. Dist. No.

10256

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER TOWN</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENNEDYVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S HOSP</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>L.</b> Last <b>BRUCKSON</b>				4. DATE OF DEATH Month <b>SEP</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 9, 1895</b>		9. AGE (In years last birthday) <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HONE</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ANDREW LEX BOLD</b>				14. MOTHER'S MAIDEN NAME <b>SARA WHITLOCK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSP CHART</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, generalized</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last, (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9:25</b> , 19 <b>58</b> , to <b>9:28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9:28</b> , 19 <b>58</b> , and that death occurred at <b>9:28 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chester town</b> DATE SIGNED <b>9-28-58</b>							
ACTUAL SIGNATURE <b>Arthur T. Keefe, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ARTHUR T. KEEFE, JR. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GEORGETOWN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>GEORGETOWN, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 1 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

CERTIFICATE OF DEATH

10-24

Page One of One

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>10-24-1918</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. OCCASION OF DEATH <i>Heart Disease</i></p>		<p>8. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>11. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>14. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>15. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>16. SIGNATURE OF JURY <i>John Doe</i></p>		<p>17. SIGNATURE OF JURY <i>John Doe</i></p>		<p>18. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>19. SIGNATURE OF JURY <i>John Doe</i></p>		<p>20. SIGNATURE OF JURY <i>John Doe</i></p>		<p>21. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>22. SIGNATURE OF JURY <i>John Doe</i></p>		<p>23. SIGNATURE OF JURY <i>John Doe</i></p>		<p>24. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>25. SIGNATURE OF JURY <i>John Doe</i></p>		<p>26. SIGNATURE OF JURY <i>John Doe</i></p>		<p>27. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>28. SIGNATURE OF JURY <i>John Doe</i></p>		<p>29. SIGNATURE OF JURY <i>John Doe</i></p>		<p>30. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>31. SIGNATURE OF JURY <i>John Doe</i></p>		<p>32. SIGNATURE OF JURY <i>John Doe</i></p>		<p>33. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>34. SIGNATURE OF JURY <i>John Doe</i></p>		<p>35. SIGNATURE OF JURY <i>John Doe</i></p>		<p>36. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>37. SIGNATURE OF JURY <i>John Doe</i></p>		<p>38. SIGNATURE OF JURY <i>John Doe</i></p>		<p>39. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>40. SIGNATURE OF JURY <i>John Doe</i></p>		<p>41. SIGNATURE OF JURY <i>John Doe</i></p>		<p>42. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>43. SIGNATURE OF JURY <i>John Doe</i></p>		<p>44. SIGNATURE OF JURY <i>John Doe</i></p>		<p>45. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>46. SIGNATURE OF JURY <i>John Doe</i></p>		<p>47. SIGNATURE OF JURY <i>John Doe</i></p>		<p>48. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>49. SIGNATURE OF JURY <i>John Doe</i></p>		<p>50. SIGNATURE OF JURY <i>John Doe</i></p>		<p>51. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>52. SIGNATURE OF JURY <i>John Doe</i></p>		<p>53. SIGNATURE OF JURY <i>John Doe</i></p>		<p>54. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>55. SIGNATURE OF JURY <i>John Doe</i></p>		<p>56. SIGNATURE OF JURY <i>John Doe</i></p>		<p>57. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>58. SIGNATURE OF JURY <i>John Doe</i></p>		<p>59. SIGNATURE OF JURY <i>John Doe</i></p>		<p>60. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>61. SIGNATURE OF JURY <i>John Doe</i></p>		<p>62. SIGNATURE OF JURY <i>John Doe</i></p>		<p>63. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>64. SIGNATURE OF JURY <i>John Doe</i></p>		<p>65. SIGNATURE OF JURY <i>John Doe</i></p>		<p>66. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>67. SIGNATURE OF JURY <i>John Doe</i></p>		<p>68. SIGNATURE OF JURY <i>John Doe</i></p>		<p>69. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>70. SIGNATURE OF JURY <i>John Doe</i></p>		<p>71. SIGNATURE OF JURY <i>John Doe</i></p>		<p>72. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>73. SIGNATURE OF JURY <i>John Doe</i></p>		<p>74. SIGNATURE OF JURY <i>John Doe</i></p>		<p>75. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>76. SIGNATURE OF JURY <i>John Doe</i></p>		<p>77. SIGNATURE OF JURY <i>John Doe</i></p>		<p>78. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>79. SIGNATURE OF JURY <i>John Doe</i></p>		<p>80. SIGNATURE OF JURY <i>John Doe</i></p>		<p>81. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>82. SIGNATURE OF JURY <i>John Doe</i></p>		<p>83. SIGNATURE OF JURY <i>John Doe</i></p>		<p>84. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>85. SIGNATURE OF JURY <i>John Doe</i></p>		<p>86. SIGNATURE OF JURY <i>John Doe</i></p>		<p>87. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>88. SIGNATURE OF JURY <i>John Doe</i></p>		<p>89. SIGNATURE OF JURY <i>John Doe</i></p>		<p>90. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>91. SIGNATURE OF JURY <i>John Doe</i></p>		<p>92. SIGNATURE OF JURY <i>John Doe</i></p>		<p>93. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>94. SIGNATURE OF JURY <i>John Doe</i></p>		<p>95. SIGNATURE OF JURY <i>John Doe</i></p>		<p>96. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>97. SIGNATURE OF JURY <i>John Doe</i></p>		<p>98. SIGNATURE OF JURY <i>John Doe</i></p>		<p>99. SIGNATURE OF JURY <i>John Doe</i></p>	
<p>100. SIGNATURE OF JURY <i>John Doe</i></p>		<p>101. SIGNATURE OF JURY <i>John Doe</i></p>		<p>102. SIGNATURE OF JURY <i>John Doe</i></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10249

10257

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE S. Carolina b. COUNTY Kershaw	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Hosp. 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Co. Hospital		d. STREET ADDRESS 77X - 3	
3. NAME OF DECEASED (Type or print) Sidney Cunningham		4. DATE OF DEATH Sept. 22, 1958	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Reuben Cunningham		14. MOTHER'S MAIDEN NAME Sarah Halls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Don't know		16. SOCIAL SECURITY NO. 240-12-9720	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hematoma, left temporal lobe & 983x DUE TO Meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of base of skull, left temporal & sphenoid bones DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 days 4 days 8 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) struck on left side of head with a gallon jug	
20c. TIME OF INJURY Month, Day, Year 1:00PM 9/14/58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Near Chestertown, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 9/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/58	
22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waley		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DA SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 10250

10258

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>adult life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 Lynchburg St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Green</b> First <b>Goldsborough</b> Middle Last		4. DATE OF DEATH <b>Sept. 21, 1958</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 1, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>various</b>	
11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Goldsborough</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Jennie Goldsborough</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>794X Semidity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 19, 1958</b> to <b>Sept 21, 1958</b> , that I last saw the deceased alive on <b>Sept 19, 1958</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eugene Kester</b>		ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>9/22/58</b>	
PHYSICIAN'S NAME (Type) <b>Eugene Kester</b>		M.D. <b>Rock Hall, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rich Neck Hall Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>nr. Church Hill, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Wadley</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 10259 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10251

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>14 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STILL POND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT + QUEEN ANNES HOSPITAL</u>			d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Gertrude</u> Last <u>Hepburn</u>			4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1884</u>		9. AGE (In years lost birthday) yrs. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>WILLIAM D. PENNINGTON</u>		
14. MOTHER'S MAIDEN NAME <u>ELLA G. SPARKS</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>HOSPITAL RECORDS</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Perforation Diverticula + Acute peritonitis Postoperative 1 wk</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>58</u> , to <u>9/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>58</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thomas J. Solon</u>		M.D. <u>Chestertown</u>		DATE SIGNED <u>9/8/58</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS J. SOLON</u>		<u>CHESTERTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>I. U. CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>WORTON, MD.</u>		(State) <u>MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>			

CERTIFICATE OF DEATH

1918

NAME OF DECEASED WILLIAM J. FENNELL JR.		SEX MALE		AGE 32		DATE OF BIRTH JAN 1 1886		PLACE OF BIRTH BALTIMORE, MARYLAND	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		OCCUPATION CLOCK MAKER		RELIGION METHODIST		MILITARY SERVICE U.S. ARMY	
CAUSE OF DEATH HEART DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME		DATE OF DEATH FEB 15 1918		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. H. [illegible]		SIGNATURE OF WITNESSES [illegible]		SIGNATURE OF DECEASED [illegible]		SIGNATURE OF NEXT OF KIN [illegible]		SIGNATURE OF REGISTRAR [illegible]	
DATE OF REGISTRATION FEB 16 1918		PLACE OF REGISTRATION BALTIMORE		NAME OF REGISTRAR [illegible]		NAME OF PHYSICIAN [illegible]		NAME OF WITNESSES [illegible]	

10260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT &amp; Queen Anne's</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Lewin</u> Middle <u>T</u> Last <u>Hyland</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector for the water Fisheries</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Hyland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Emma Hyland Rock Hall</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> o. ft. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG. 26, 1958</u> , to <u>Sept 8, 1958</u> , that I last saw the deceased alive on <u>3:00 AM Sept 8, 1958</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Paul Ross</u>		ADDRESS (Street, city or town, state) <u>203 N. Queen St, Chestertown, Md</u>	
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>		DATE SIGNED <u>Sept 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ES Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



10261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Millington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's Hospital</b>				d. STREET ADDRESS <b>/ Travilla Farm, Morgnec Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence C Jenkins</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 13, 1882</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Publisher Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John G. Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>056-09-2593</b>		17. INFORMANT Address <b>Hospital records—Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cystitis, prostatitis, aortic aneurysm</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>9-9</b> , 19 <b>58</b> , to <b>9-18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-17-58</b> , 19 <b>58</b> , and that death occurred at <b>1:40 a. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>9-18-58</b>							
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.				CHESTERTOWN, MD.			
PHYSICIAN'S NAME (Type) <b>A.C. Dick, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md. RFD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Wells</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10265

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katherine Clara Joiner</b>		4. DATE OF DEATH Month Day Year <b>September 14, 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1869</b>
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Henry Wells</b>		14. MOTHER'S MAIDEN NAME <b>Annie Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Bernette Baxter</b>		Address <b>Still Pond, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple cerebrovascular accidents</b> <b>331 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pleurisy 5 weeks ago.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/28, 1955</b> , to <b>Sept 14, 1958</b> , that I last saw the deceased alive on <b>Sept 13, 1958</b> , and that death occurred at <b>2:58 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Florence Deringer Joyce M.D. Worton 9/14/58</b>			
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b>		PHYSICIAN'S NAME (Type) <b>Florence Deringer Joyce Worton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		ADDRESS <b>Still Pond, Md.</b>	24a. REC'D BY REGISTRAR <b>SEP 16 58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10262

## CERTIFICATE OF DEATH

10255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Reuben</b> Middle <b>Manuel</b> Last <b>Manuel</b>		4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Manuel</b>		14. MOTHER'S MAIDEN NAME <b>Marcella Blake</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-2780</b>	
17. INFORMANT <b>Mrs. Lottie Strong, Rock Hall, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the prostate</b> DUE TO (c) <b>//??</b>		INTERVAL BETWEEN ONSET AND DEATH <b>??</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-4</b> , 19 <b>58</b> , to <b>9-5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-5-58</b> , 19 <b>58</b> , and that death occurred at <b>9:05a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>9-8-58</b>			
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.			
PHYSICIAN'S NAME (Type) <b>A.C. Dick, Chestertown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sharptown Col. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1955

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1920	
5. PLACE OF BIRTH Jackson, Tennessee		6. OCCUPATION Author		7. MARITAL STATUS Single		8. COLOR White	
9. DATE OF DEATH April 4, 1968		10. PLACE OF DEATH Nashville, Tennessee		11. CAUSE OF DEATH Gunshot wound		12. MANNER OF DEATH Suicide	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN Mrs. Lorene Green, 1001 Hill, No. 1		15. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		16. SIGNATURE OF CORONER J. H. Hume	
17. SIGNATURE OF REGISTRAR J. H. Hume		18. SIGNATURE OF CLERK J. H. Hume		19. SIGNATURE OF JURY J. H. Hume		20. SIGNATURE OF JUDGE J. H. Hume	

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10266 CERTIFICATE OF DEATH

10256

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home RFD Colemans</b>				e. STREET ADDRESS <b>1 Coleman's Corner</b>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Moody</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> , 1958 Year <b>19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1, 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>	
13. FATHER'S NAME <b>Sewell White</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Snowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>James Moody (husband)</b> Address <b>RFD Worton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of liver (metastatic)</b> DUE TO (c) <b>Carcinoma of left ovary</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 years</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>all rheumatic valvular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May</b> , 1953, to <b>Sept</b> , 1958, that I last saw the deceased alive on <b>Sept 7</b> , 1958, and that death occurred at <b>2:30 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Worton Md</b> DATE SIGNED <b>9/ /58</b>							
ACTUAL SIGNATURE <b>Florence D. Joyce</b> M.D.				PHYSICIAN'S NAME (Type) <b>Florence D. Joyce</b> <b>Worton, Md. RFD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Coleman's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Worton RFD Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR 18

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

DATE OF INTERMENT: \_\_\_\_\_

PLACE OF INTERMENT: \_\_\_\_\_

NAME OF FUNERAL HOME: \_\_\_\_\_

NAME OF MINISTER: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

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NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10257

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>		c. LENGTH OF STAY IN 1b <b>3 YRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>TARBUTTON</b> Middle <b>NEWSOME</b> Last		4. DATE OF DEATH <b>September 29</b> Day <b>29</b> Month <b>September</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Agency</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Louis Newsome</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH E. CREW</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>213-01-2412</b>		17. INFORMANT Address <b>Mr. Frank Newsome, Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis</b> causing the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Short time</b> <b>Many years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deceased had had heart trouble for many years but had not been attended by a physician for a long time. He frequently took nitroglycerine tablets. Was last seen alive by his nephew with whom he lived when he went to bed night of 9/28/58 at about 10:00 PM</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>at about 10:00 PM</b>		20b. INJURY OCCURRED 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at work</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22b. DATE THEREOF <b>10-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>STILL POND CEMT</b>	
22d. LOCATION (City, town, or county) (State) <b>STILL POND MD.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>	
24a. REC'D BY REGISTRAR <b>1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraw</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
AND STATE DEPARTMENT OF HEALTH - BATHING

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF DEATH

RESIDENCE

PLACE OF DEATH

DATE OF EXAMINATION  
PLACE OF EXAMINATION

EXAMINER'S SIGNATURE

DATE OF DEATH  
PLACE OF DEATH

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DATE OF DEATH  
PLACE OF DEATH

EXAMINER'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10268

## CERTIFICATE OF DEATH

10258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Ethel Urie Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George William Taylor		4. DATE OF DEATH Month Sept. 29 Day 29 Year 19 58	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1872
9. AGE (In years day birthday yrs.) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tug boat capt.	
11. BIRTHPLACE (State or foreign country) Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Medford Taylor		14. MOTHER'S MAIDEN NAME Mary Eliz. Downey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-18-7928	
17. INFORMANT Mrs. Ethel Bramble-Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Chronic degenerative Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema & Myocardial Infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1948, to Sept 29, 1958, that I last saw the deceased alive on Sept 28, 1958, and that death occurred at 7:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Norbet C. Nitch M.D. Rock Hall Maryland PHYSICIAN'S NAME (Type) Norbet C. Nitch Rock Hall, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2/58	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams--		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 M 10269 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

11431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CRUMPTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WENTON RURAL 05x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>CHARLES WESLEY WRIGHT</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM TENANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALICE WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>WILHELMINA LOCKERMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Charles Wright Denton, Ind.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>931X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 9</u> , 19 <u>58</u> , to <u>Sept 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 24</u> , 19 <u>58</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geza Koralewski</u>				ADDRESS (Street, city or town, state) <u>MILKINGTON MD.</u>		DATE SIGNED <u>9.25.58</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>near Denton, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Leonardson Denton, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>	

